XAVIER BECERRA
Attorney General of California
KENT D. HARRIS
Supervising Deputy Attorney General
KEVIN W. BELL
Deputy Attorney General
State Bar No. 192063
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7511
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LINDA MARIE SCROGGY** **AKA LINDA MARIE ETTENSOHN** **191 North Tully Road** **Turlock, CA 95380** **Registered Nurse License No. 379612** **Nurse Practitioner Certificate No. 11555** **Nurse Practitioner Furnishing Certificate No. 11555** Respondent.	Case No. 2020-37 **ACCUSATION**

PARTIES

1. Joseph L. Morris, PhD, MSN, RN ("Complainant") brings this Accusation solely in his official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse

2. On or about October 31, 1984, the Board issued Registered Nurse License Number 379612 to Linda Marie Scroggy, also known as Linda Marie Ettensohn ("Respondent"). The RN license expired on August 31, 2018, and has not been renewed.

Nurse Practitioner Certificate

3. On or about May 17, 2000, the Board issued Nurse Practitioner Certificate Number 11555 to Respondent. The nurse practitioner certificate expired on August 31, 2018, and has not been renewed.

Nurse Practitioner Furnishing Certificate

4. On or about July 6, 2001, the Board issued Nurse Practitioner Furnishing Certificate Number 11555 to Respondent. The nurse practitioner furnishing certificate expired on August 31, 2018, and has not been renewed.

JURISDICTION

5. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY PROVISIONS

7. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section ("Regulation") 1441 states, in pertinent part:

> In addition to the conduct described in Section 2761 (a) of the Code, "unprofessional conduct" also includes, but is not limited to, the following:
>
> . . . .

(b) Failure to cooperate and participate in any board investigation pending against the licensee. This subsection shall not be construed to deprive a licensee of any privilege guaranteed by the Fifth Amendment to the Constitution of the United States, or any other constitutional or statutory privileges. This subsection shall not be construed to require a licensee to cooperate with a request that would require the licensee to waive any constitutional or statutory privilege or to comply with a request for information or other matters within an unreasonable period of time in light of the time constraints of the licensee's practice. Any exercise by a licensee of any constitutional or statutory privilege shall not be used against the licensee in a regulatory or disciplinary proceeding against the licensee.

9. Regulation 1442 states:

As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care, which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

10. Regulation 1443 states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5..

11. Regulation 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

12. Regulation 1474 states:

Following are the standardized procedure guidelines jointly promulgated by the Medical Board of California and by the Board of Registered Nursing:

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) Be in writing, dated and signed by the organized health care system personnel authorized to approve it.

(2) Specify which standardized procedure functions registered nurses may perform and under what circumstances.

(3) State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.

(4) Specify any experience, training, and/or education requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

(7) Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a physician concerning the patient's condition.

(9) State the limitations on settings, if any, in which standardized procedure functions may be performed.

(10) Specify patient record keeping requirements.

(11) Provide for a method of periodic review of the standardized procedures.

COST RECOVERY

13. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and

enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

CONTROLLED SUBSTANCES

14. **Alprazolam** is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(1).

15. **Amphetamine** is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (d)(1).

16. **Clonazepam** is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(7).

17. **Dextroamphetamine** is a Schedule II controlled substance as designated by Health and Safety Code section 11055(d)(1).

18. **Hydrocodone Bitartrate** – Acetaminophen is a Schedule III controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(I).

19. **Oxycodone HCL** – Acetaminophen is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

20. **Carisoprodol** is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(17).

21. **Zolpidem** is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(32).

BACKGROUND INFORMATION

22. At all times relevant to the charges brought herein, Respondent was employed and on duty as a furnishing nurse practitioner with St. Mary's Urgent Care ("SMUC") in Stockton, California.

23. In and between October 19, 2012 and April 7, 2013, Respondent provided care for a 41-year old woman ("Patient 1") at SMUC. During that time, Respondent prescribed to Patient 1 the following controlled substances: clonazepam, carisoprodol, hydrocodone bitartrate-acetaminophen, Oxycodone HCL-acetaminophen, alprazolam, and zolpidem.

24. In and between February 2, 2013, and April 3, 2013, Respondent prescribed the following controlled substances to Patient 1: one-hundred and twenty (120) tablets of oxycodone 325 mg/10 mg; sixty (60) tablets of alprazolam 0.5 mg; thirty (30) tablets of zolpidem 10 mg; and, a total of two hundred and seventy (270) tablets of clonazepam. 2 milligrams ("mg").

25. The total amount of clonazepam prescribed to Patient 1 within a two-month period (as identified above in paragraph 23) equates to 9 mg per day, which highly exceeds the recommended therapeutic dosing. Further, a Black Box Warning[1] exists that states "concomitant use with opioids may result in profound sedation, respiration depression, coma and death"

26. No records exist to show Respondent monitored or educated her patients on the risks associated with use and possible misuse of Schedule II medications prescribed and the warnings for the two drug categories: opioids and benzodiazepines.

27. On or about April 7, 2013, Patient 1, who was under the care of Respondent at the time, was found non-responsive in her home. Patient 1 was transported to the hospital, but was pronounced dead shortly after due to an accidental overdose from elevated levels of clonazepam, diphenhydramine, hydroxyzine, methadone EDDP[2], and Naloxone in her system.

28. On or about November 10, 2016, Respondent prescribed to herself esterified estrogens-methyltestoste.[3] On or about March 13, 2016, Respondent prescribed thirty (30) tablets of the controlled substance temazepam to herself, against discouragement for advance practice nurses to write prescriptions to themselves as a patient, especially with Schedule II medication.

29. On or about April 19, 2017, the Board received a complaint against Respondent alleging she over prescribed medications to patients and prescribed unsafe combinations of medications, which led to a patient's overdose.

30. On or about September 11, 2017 through June 8, 2018, the Board made twelve (12) attempts to contact Respondent via email, telephone, in-person appearance, mailed

---

[1] Black Box Warning/Label is a notice on a prescription label, which identifies potentially serious and life-threatening risks of a drug. It is the most serious type of warning in the prescription drug labeling identified by the United States Food and Drug Agency (FDA).

[2] The EDDP is the metabolite of methadone, a substitution treatment against heroin additions, and can be found in urine.

[3] Oral hormones that required a prescription by a licensed provider.

correspondence, and subpoenas requiring Respondent to provide testimony in a Board investigation. The attempts were not successful. In fact, the Board received the mailed correspondence (a total of eight) as returned with a notice "unable to forward." Thus, Respondent failed to keep an updated address of record with the Board.

31. On or about March 2, 2018, in a telephone interview with a Board investigator, M.G., a medical doctor and former partner of SMUC, informed the investigator that he observed issues with Respondent prescribing high amounts of medication to patients. M.G. informed the investigator that Respondent advertised herself as a pain management practitioner. Further, M.G. noted that he observed her to appear "wobbly" at times.

32. On or about March 2, 2018, a Board investigator met with A.K., a medical doctor and former partner of SMUC. A.K. informed the investigator that SMUC ultimately closed due to Respondent and her behavior. A.K. discovered that Respondent and the office manager made and sold fake recommendation letters for their friends. A.K. also noticed triplicate prescription forms missing and/or triplicate prescription forms used quickly to write prescriptions. A.K. stated that Respondent prescribed medications to her friends and boyfriend. Further, Respondent did not keep up her appearance, looked "drugged," and arrived to work under the influence at times. A.K. informed the investigator that Respondent's method of prescribing was alarming because she combined benzodiazepines with narcotic pain medications. A.K told Respondent not to prescribe such medications in that manner, but Respondent refused to comply. The Board investigator inquired about A.K.'s signature on the Impairment Questionnaire form dated November 26, 2013. Respondent included this form with a letter signed by Respondent in response to J.M.'s (identified as Respondent's significant other) denial for disability. A.K. denied signing or approving such form.

33. The Board investigator received a copy of Respondent's employment records that included an anonymous note stating "Linda making disability fraud for her boyfriend. Using office templates + signatures to make case."

///

///

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

34. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), in conjunction with Regulation 1442, on the grounds of unprofessional conduct, in that in and between October 19, 2012, and April 7, 2013, while on duty as a furnishing nurse practitioner at SMUC located in Stockton, California, Respondent was grossly negligent, as follows:

a. Respondent over-prescribed controlled substances in quantity and sooner than should have been prescribed for safety; and,

b. Respondent prescribed combinations of medications known to cause significant central nervous system depression, respiratory depression, coma and death when taken in combination, as noted in the Black Box Warnings.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

35. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), in conjunction Regulation 1443, on the grounds of unprofessional conduct, in that in and between October 19, 2012, and April 7, 2013, while on duty as a furnishing nurse practitioner at SMUC located in Stockton, California, Respondent demonstrated incompetence, as more particularly set forth above in paragraph 34 and as follows: Respondent failed to follow the standardized procedures regarding disability paperwork when she submitted her boyfriend's Impairment Questionnaire form without her supervising physician's knowledge and to a person known personally to her, as more particularly set forth above in paragraph 32.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

36. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), in that in and between October 19, 2012, and April 7, 2013, while on duty as a furnishing nurse practitioner at SMUC located in Stockton, California, Respondent demonstrated unprofessional conduct as more particularly set forth above in paragraphs 34 and 35 and as follows:

a. Respondent failed to cooperate in the Board investigation; and,

b. Respondent failed to update the Board with her current address of record.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 379612, issued to Linda Marie Scroggy, also known as Linda Marie Ettensohn;

2. Revoking or suspending Nurse Practitioner Certificate Number 11555, issued to Linda Marie Scroggy, also known as Linda Marie Ettensohn;

3. Revoking or suspending Nurse Practitioner Furnishing Certificate Number 11555, issued to Linda Marie Scroggy, also known as Linda Marie Ettensohn;

4. Ordering Linda Marie Scroggy, also known as Linda Marie Ettensohn, to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

5. Taking such other and further action as deemed necessary and proper.

DATED: July 11, 2019

JOSEPH L. MORRIS, PHD, MSN, RN
for Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2018102751
13717141.docx